STAFF WORK ADVISORY TEAM
QUESTIONS AND ANSWERS REGARDING
GENERAL ISSUES

Q1. What is the standard for timeliness of writing progress notes, e.g., the time from when the service was provided to the time when the clinician writes the progress note for that service?

A1. The standard is "reasonable" timeliness. DMH reviewers would accept, as reasonable, a late note written within two weeks from the date of service.

Proper documentation of a late entry should include: Indication as a "late entry" as well as the date of the late entry and the initials of the author.

Q2. Can a beneficiary have more than one client plan?

A2. Yes. MHPs may permit providers to develop client plans that cover only the services to be delivered by that provider.

Q3. Can an MHP charge Medi-Cal beneficiaries a co-payment?

A3. California Code of Regulations, Title 9, Section 1810.365, "Beneficiary Billing," specifies situations when an MHP can collect reimbursement from a beneficiary:

1) *Other health insurance,*
2) *Medi-Cal Share-of-Cost,*
3) *Co-payments in accordance with Welfare and Institutions Code (W&IC) Section 14134 (see below)*

W&IC Section 14134 allows the MHP to collect a co-payment, generally $1.00 per outpatient visit, as long as no beneficiary is denied services because the co-payment is not collected. W&IC Section 14134 also lists specific beneficiaries who may not be charged a co-payment, including beneficiaries who are 18 years of age or younger or who are inpatients in hospitals or psychiatric health facilities. The MHP must ensure that any system established to collect co-payments is in compliance with the limits of W&IC Section 14134. The MHP may also wish to perform a cost analysis before embarking on such a venture.

***W&IC 14134**. Except for any prescription, refill, visit, service, device, or item for which the program's payment is ten dollars ($10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers as follows:*

(a) Copayment of five dollars ($5) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means any services not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.

(b) Copayment of one dollar ($1) shall be made for each drug prescription or refill.

(c) Copayment of one dollar ($1) shall be made for each visit for services under subdivisions (a) and (h) of Section 14132.

(d) The copayment amounts set forth in subdivisions (a), (b), and (c) may be collected and retained or waived by the provider.

(e) The department shall not reduce the reimbursement otherwise due to providers as a result of the copayment. The copayment amounts shall be in addition to any reimbursement otherwise due the provider for services rendered under this program.

(f) This section does not apply to emergency services, family planning services, or to any services received by:
(1) Any child in AFDC-Foster Care, as defined in Section 11400.
(2) Any person who is an inpatient in a health facility, as defined in Section 1250 of the Health and Safety Code.
(3) Any person 18 years of age or under.
(4) Any woman receiving perinatal care.

(g) Subdivision (b) does not apply to any person 65 years of age or over.

(h) A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under this section. An individual shall, however, remain liable to the provider for any copayment amount owed.